Patient Safety

New-Comers Orientation

Evans Army Community Hospital

Patient Safety Is Job One

"Modern health care presents the most complex safety challenge of any activity on Earth."

Lucian Leape, MD

Father of Modern Patient Safety

Newcomers' Objectives

1) Understand the EACH Patient Safety Goal
2) Accept the Patient Safety Expectations at EACH (Patient Centered vs. Staff Centered)
3) Discuss Reporting Process
4) Apply the 2006 National PS Goals (6)

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EACH Patient Safety Goal

Eliminate preventable medical errors

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Patient Safety & the Joint Commission

- Sentinel Event Reporting Policy since 1995
- Change in Mission Statement in 2000

  "To continuously improve **SAFETY** & quality of care provided to the public"
- Additional PS Standards 2001
- Initiated National Patient Safety Goals 2003

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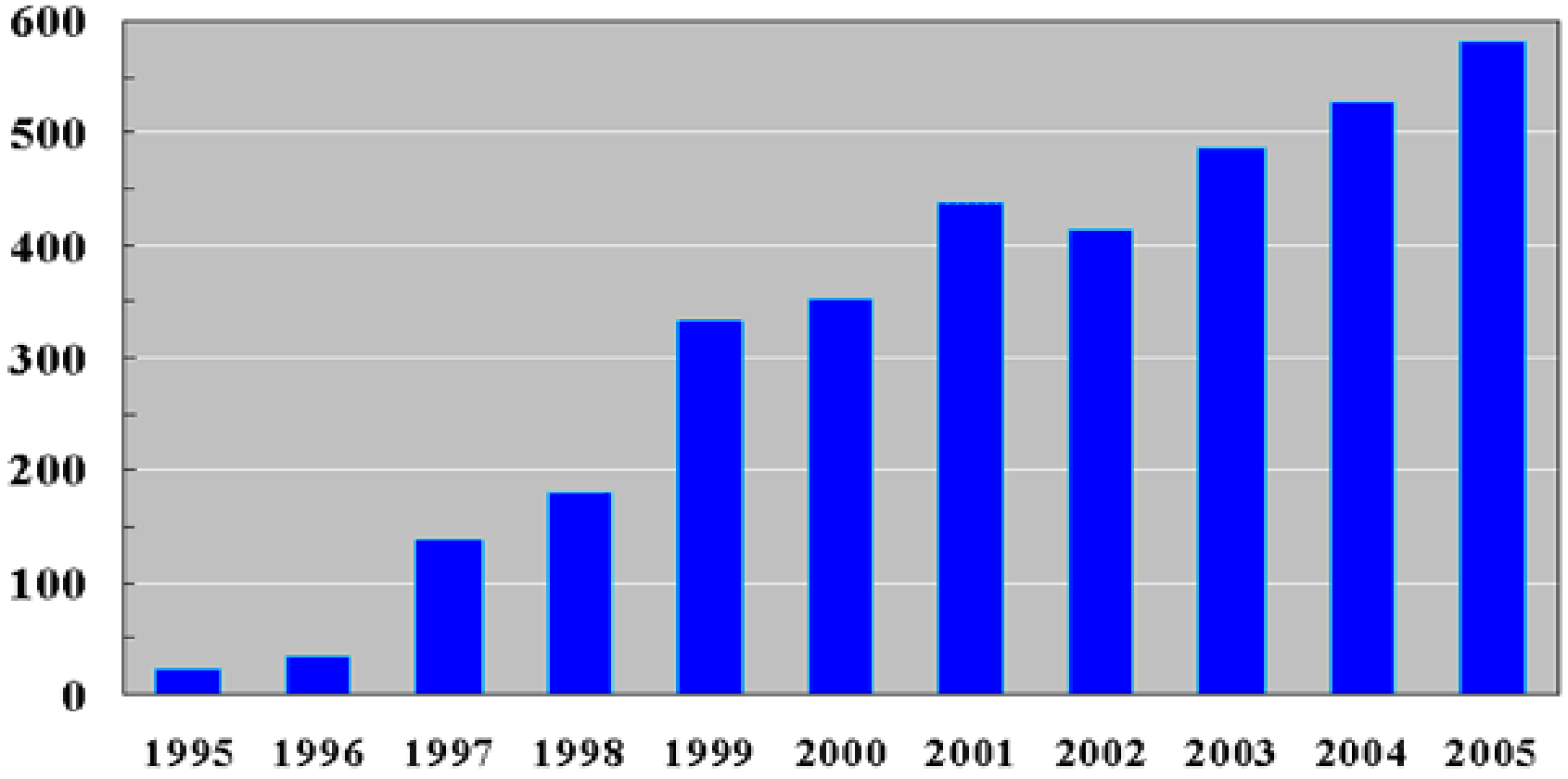
Sentinel Event Trends:

Total Sentinel Events Reported by Year



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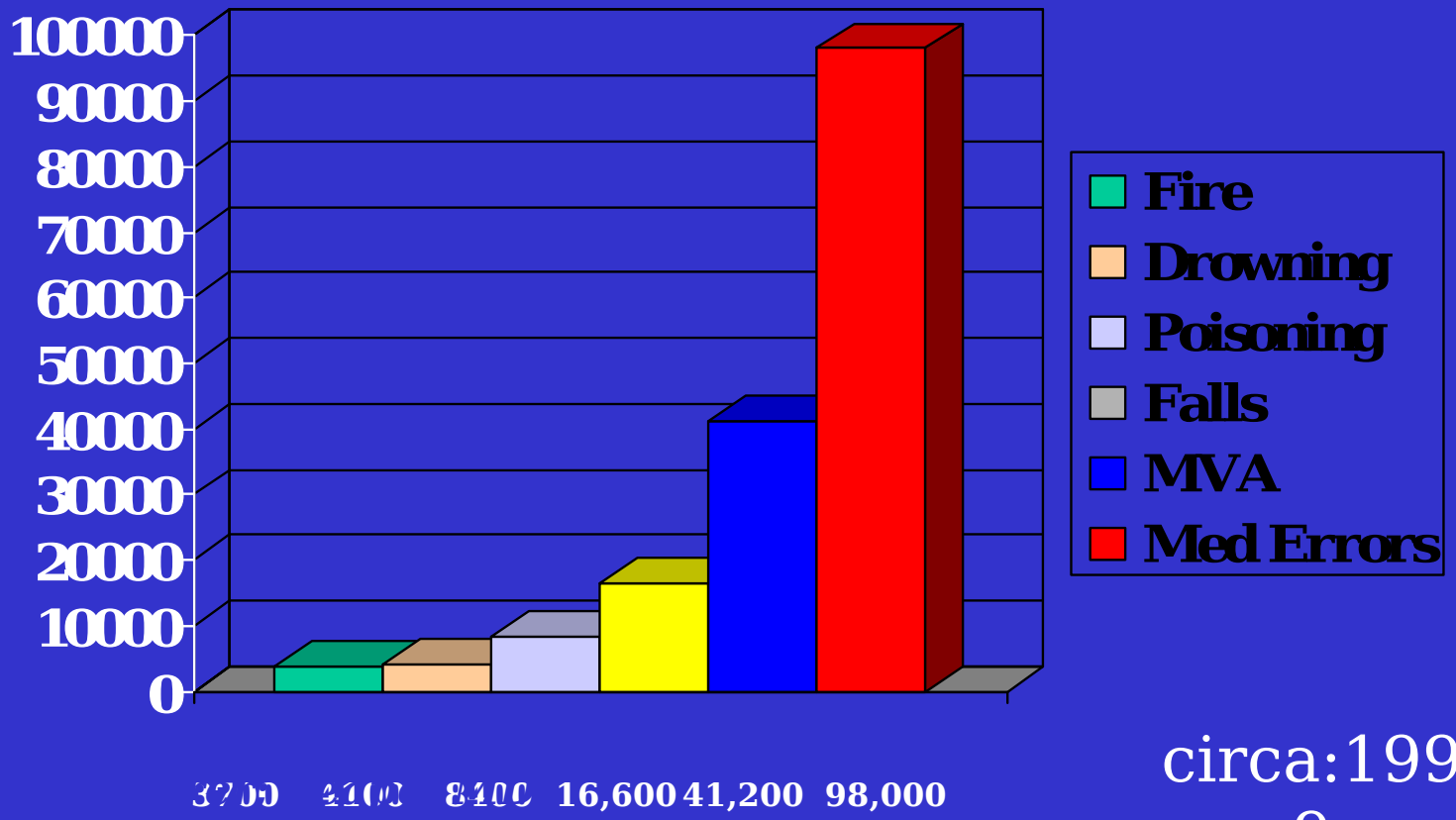
Lies, Damned Lies, and Statistics



circa:1999

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JCAHO TOP SEs

(From 1995 – To 2005)

3,548 (1,143) Sentinel Events Reviewed by JC

464 Patient Suicide
455 Wrong Site Surgery
444 Op/Post-Op Complications
358 Medication Error
269 Delay in Treatment
189 Patient Falls
138 Patient Restraint Death/Injury
121 Assault/Rape/Homicide
109 Perinatal Death/Loss Function
94 Transfusion Error
67 Infection Related Event
66 Patient Elopement
65 Fire
58 Anesthesia Related
56 Medical Equipment Related
51 Maternal Death
43 Ventilator Death/Injury
23 Infant Abduction/Wrong Family
19 Utility Systems Related
13 Untended Foreign Body Retained
446 Other less frequent types

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DoD Top SEs

(From 2000 – To 2005)

SE Event Category	#	%
Wrong-Site/Procedure Surgery (1*)	**13 (+7)**	**29**
Op/Post-op Complication	**10**	**22**
Medication Related (2*)	**8** (+2)	**18**
Delay in Treatment (5*)	**7**	**15**
Perinatal & Maternal Death (4*)	**4**	**9**
Other	**3**	**7**
*12 Events Resulted in Unanticipated Death	**45 (+9)**	

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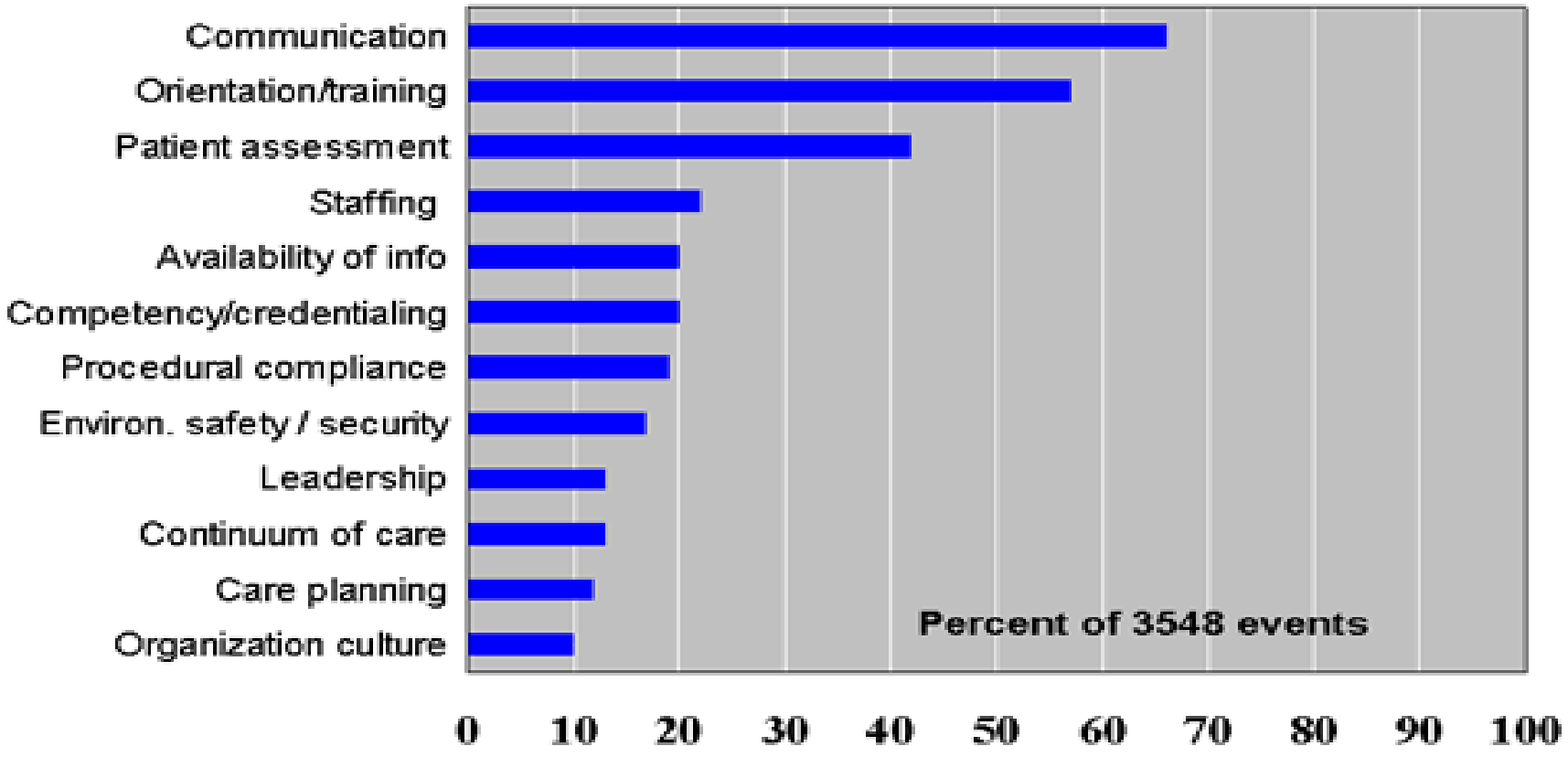
Root Causes of Sentinel Events

(All categories; 1995-2005)



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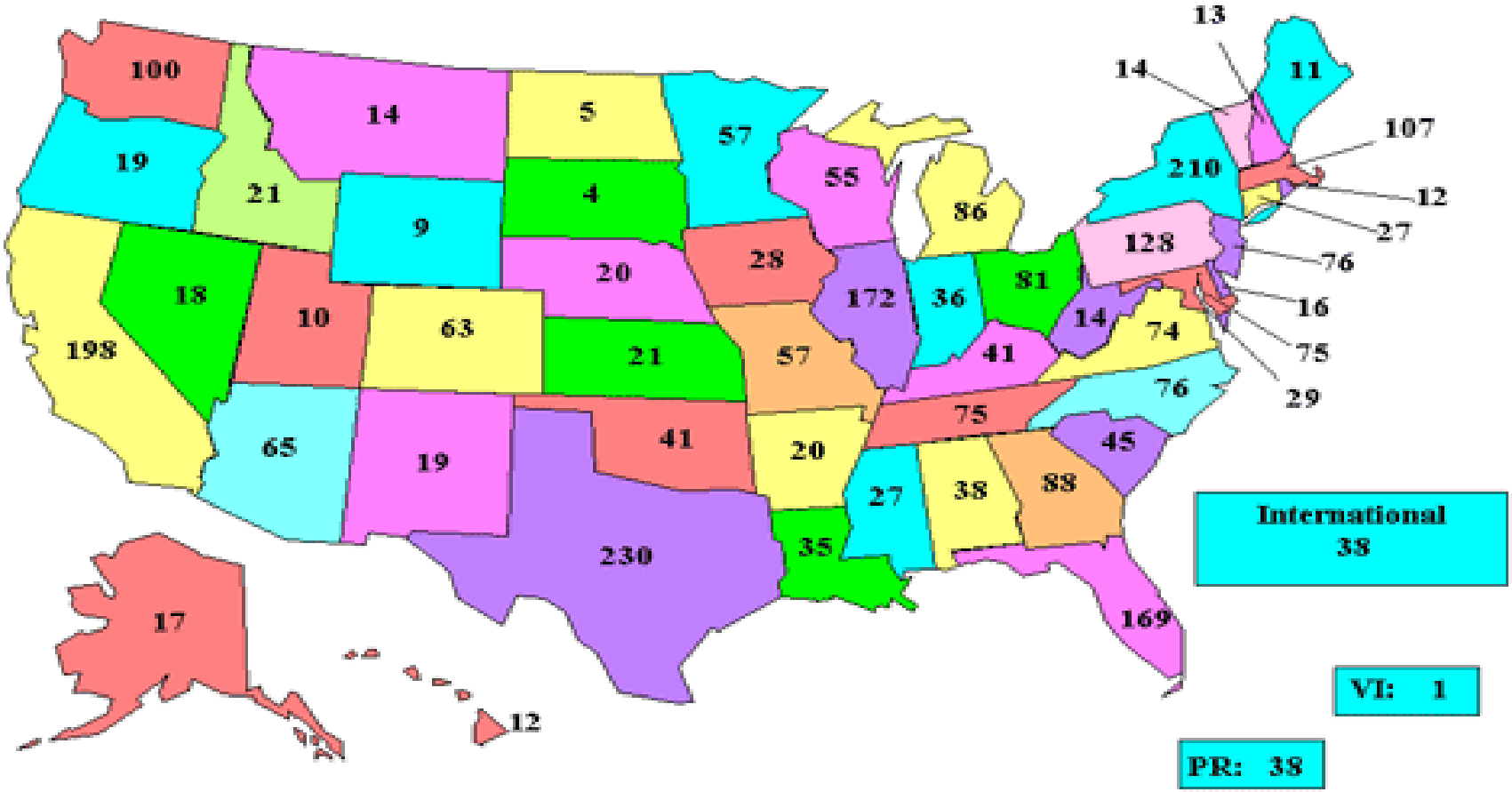
Total "Reviewed" Events by State



Top 3 Incidents at EACH

(2002 - 2005)

- **Medication Issues**
- **Laboratory Issues**
- **Practice & Procedure Variances**

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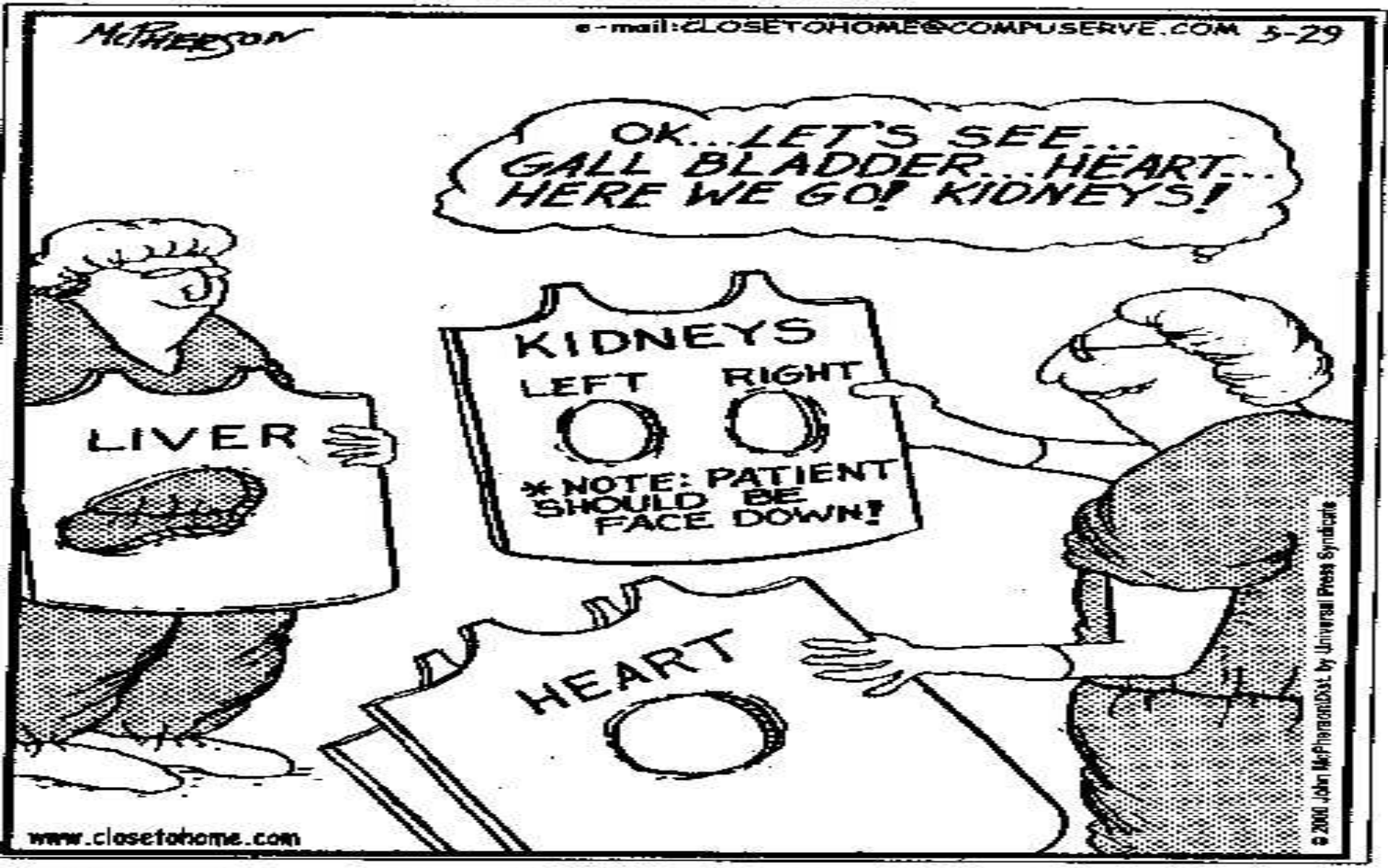
Why Are We Here?

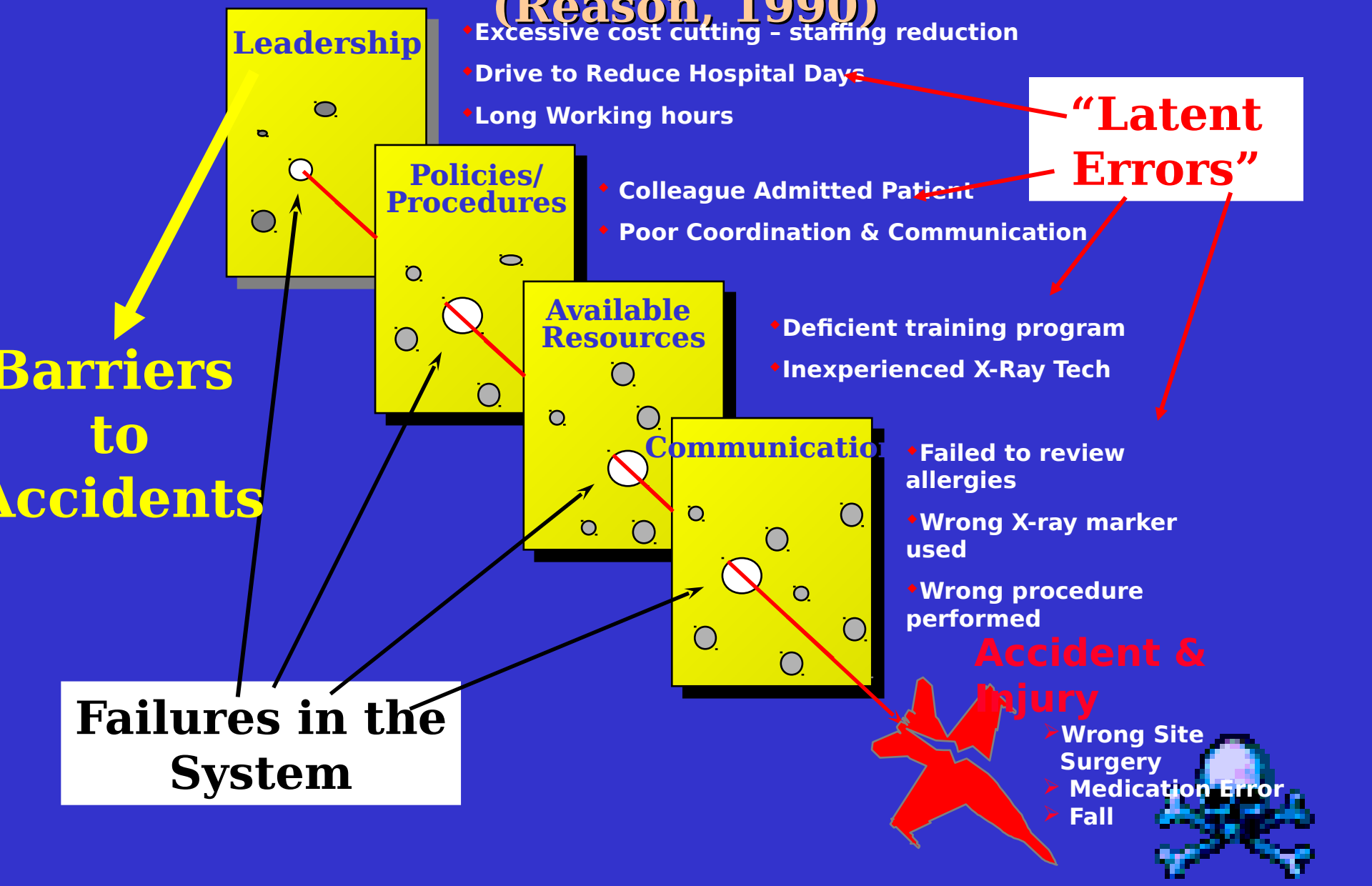
Variation is the enemy of quality

CLOSE TO HOME JOHN McPHERSON



To avoid costly mistakes in the operating room, doctors at Oakmont hospital relied on surgery templates.

The "Swiss Cheese" Model of Accident Causation (Reason, 1990)



Your Obligation

Every EACH employee has the responsibility and duty to question the decision of any other team member, without fear, at any time.

Nothing Will Change Unless You

Patient Safety Program

Brief →

De-Brief

Situational Awareness =

SBAR

Situation

Background

Assessment

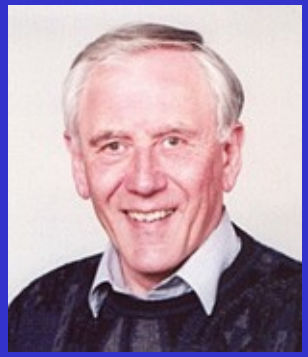
Recommendation

Gets Everyone On The Sheet of Music

TV

James Reason's Bottom Line

- *Fallibility is part of the human condition*
- *We can't change the human condition*
- *So, we have to change the conditions under which people work*



Father of Modern Safety Movement

Reality

"Incompetent people are, at best, 1% of the problem. The other 99% are good people trying to do a good job who make very simple mistakes and it's the processes that set them up to make these mistakes"

Lucian Leape, MD

However, a no blame environment doesn't mean the absence of accountability

Patient Centered vs. Staff Centered Care

What does this mean for you?

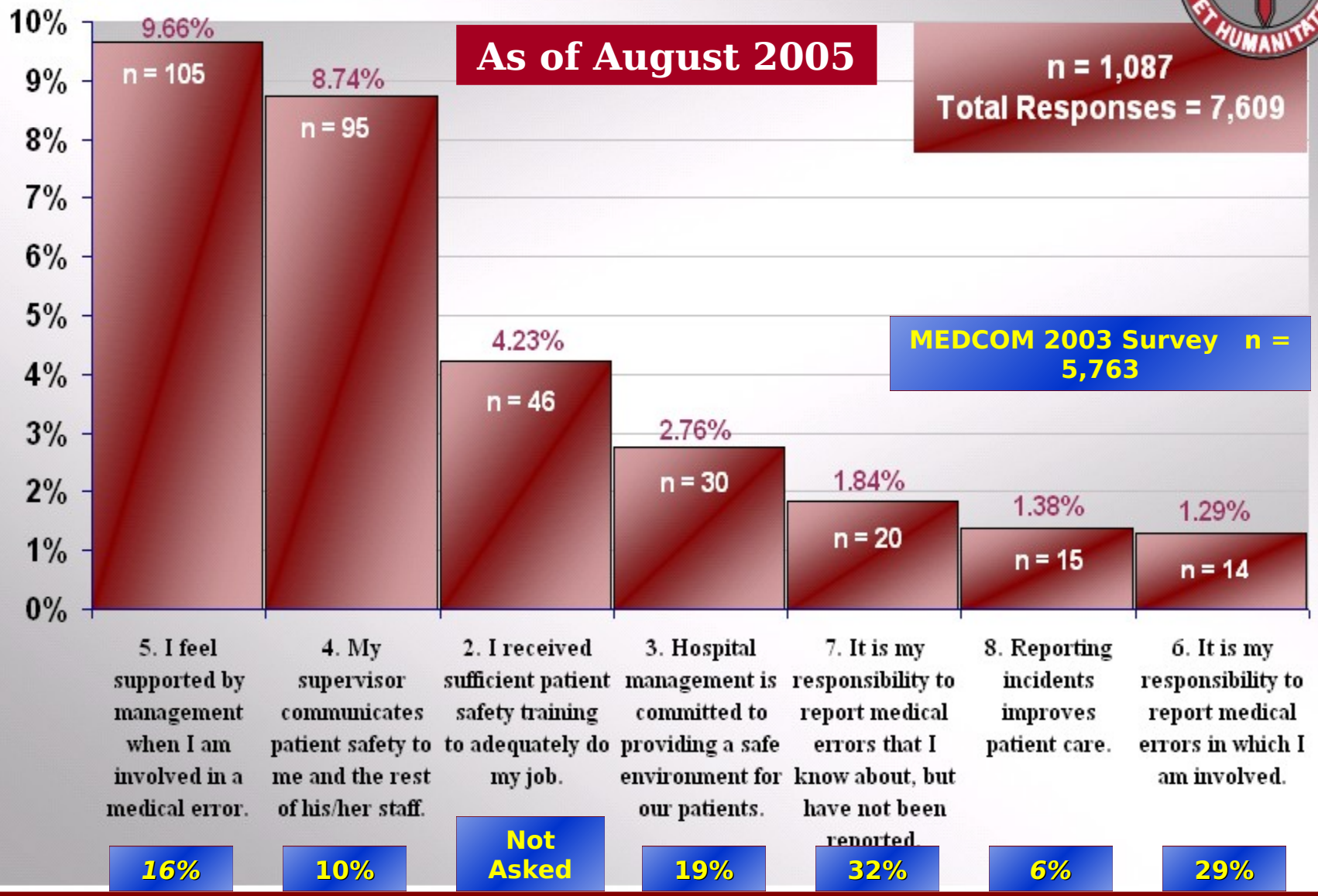
Patient Centered vs. Staff Centered Care

A culture that:

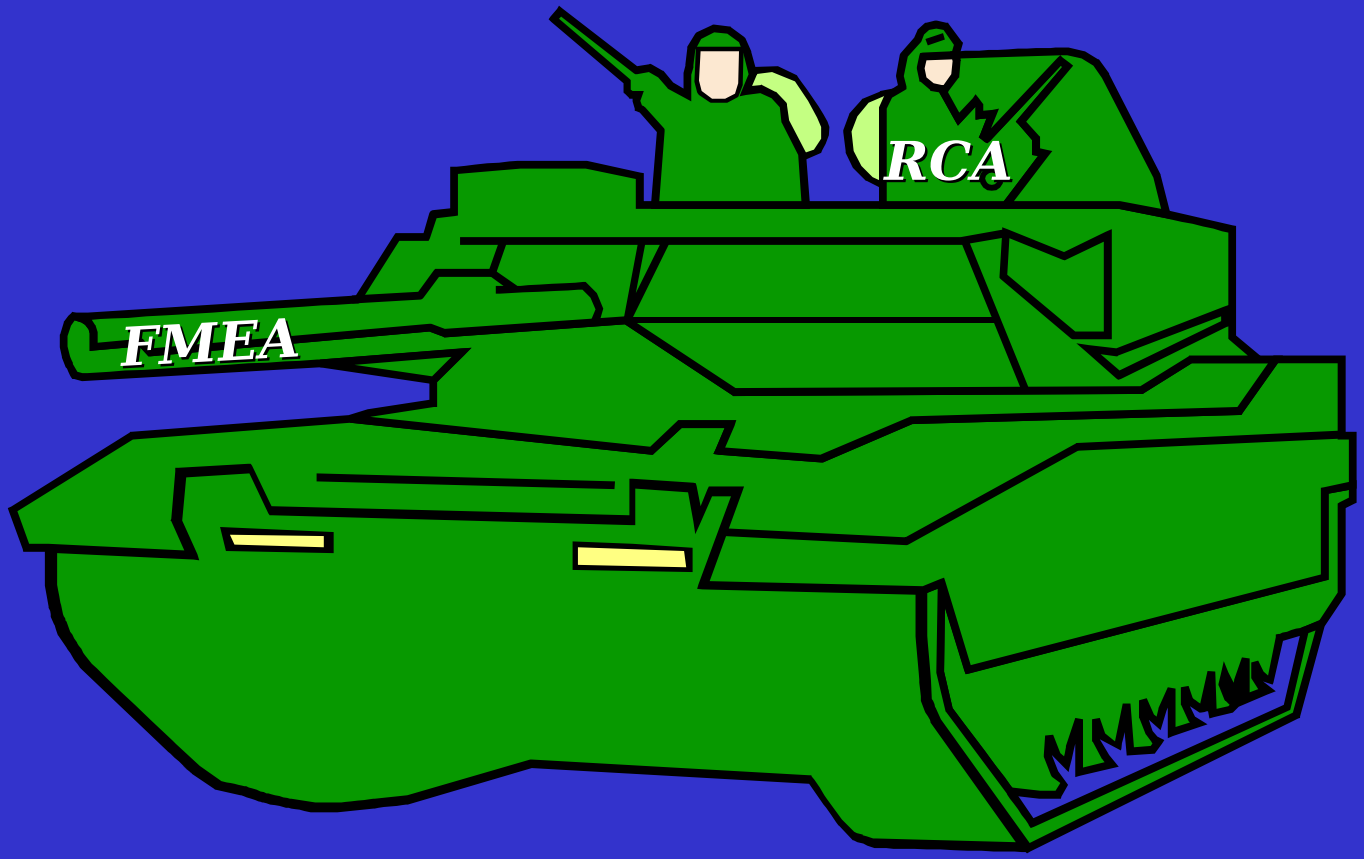
- **Does not advocate a name, blame, shame, and train philosophy,**
- **Deny that errors occur only to “bad apples,”**
- **Supports a fierce intolerance for intentional risk taking,**
- **Fair treatment for individuals making errors regardless of outcome or frequency**

Percentage of Employees Who Disagree or Strongly Disagree

325/7,609 = 4.27%



Tools Available to Combat System Errors



What is FMEA?

Failure Mode and Effect Analysis (FMEA) is a systematic method of identifying and preventing process problems before they occur.

"Think of it as Preventive Medicine for Our Health Care System."

ROOT CAUSE ANALYSIS

A tool used to systematically and objectively identify process and system "errors" resulting in variation in performance.

It's the Post Mortem (Autopsy) for a Specific Area of Our Health Care System.

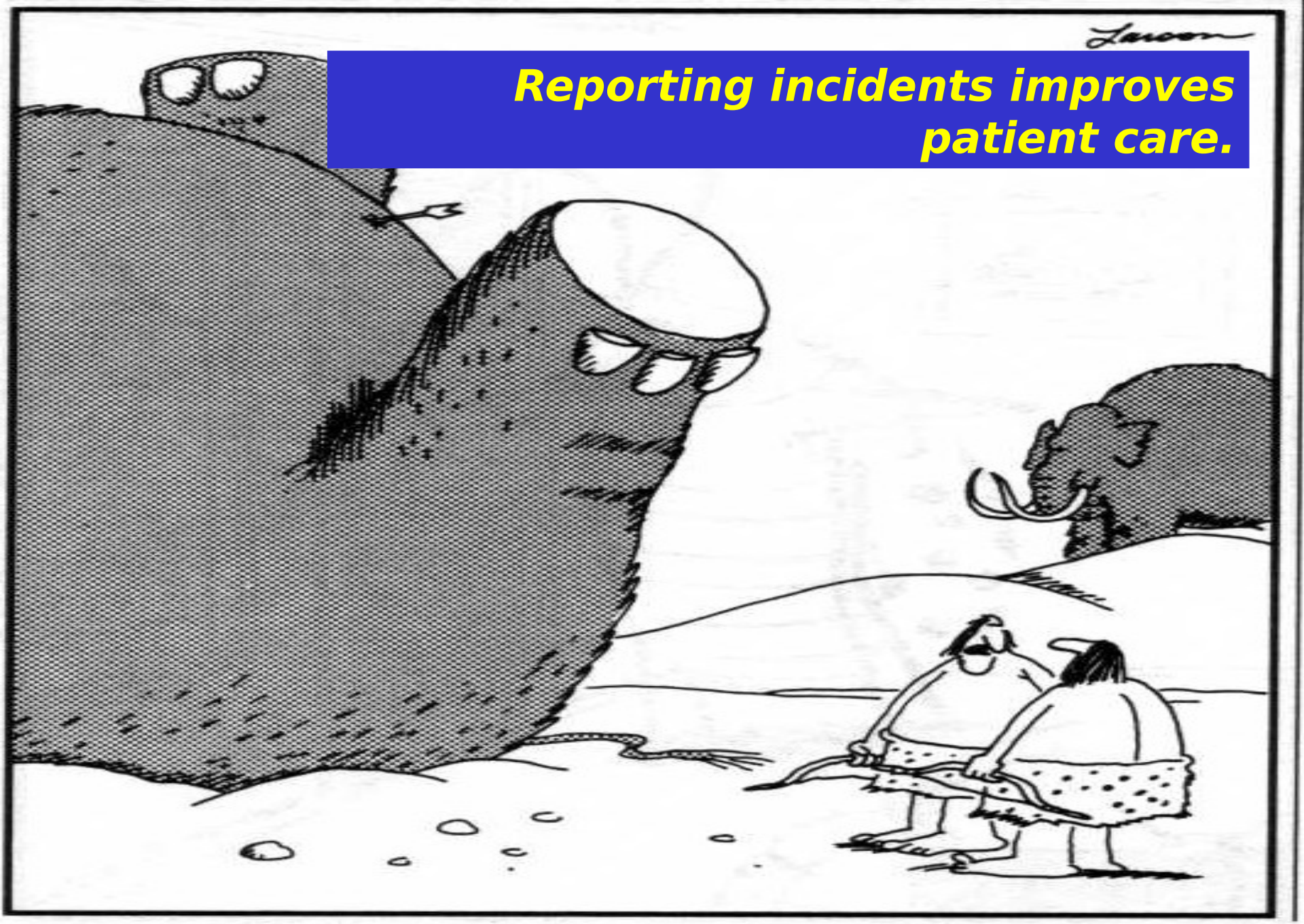
Differences Between RCA and FMEA

Root Cause Analysis	Failure Mode and Effects Analysis
Reactive	Proactive
Focuses on a Specific Patient Course of Treatment	Focuses on an entire process
Hindsight bias	Unbiased
Asks “Why?”	Asks “What if?”

Your Duty is to . . .

- **Report, Report, Report!**
  - Make Situational Awareness Happen
  - Make Patient Safety Priority
  - Be Proactive
- ***Use our e-4106 Program***

Go to EACH's Home Page To Access

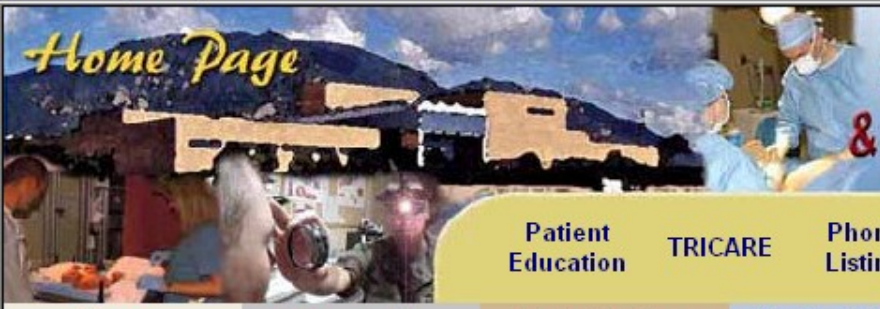

Larson
Reporting incidents improves patient care.
"Maybe we should write that spot down."

EACH_Web_Home - Page: 1 of 1 - Microsoft Internet Explorer

File Edit View Favorites Tools Help

Back Search Favorites Media

Address http://www.evans.amedd.army.mil/ Go Links



Fort Carson MEDDAC & Evans U.S Army Hospital

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- Incident (e4106) Report
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- AKO Website
- Chief of the Army Message
- Army Campaign Plan
- MEPS
- SRP
- MEDDAC Calendar

Mailing address:
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1650 Cochrane Circle
Fort Carson, CO 80913
Tel. (719) 526-7000

Medical Services

- Patient Education
- Online Prescriptions
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Secure Services

- Outlook Online
- Evans Secure Web
- Command Publications

TRICARE

Medical News

Evans has new MRI technology

An aspirin a day...

View the CFC video online (4mb file)

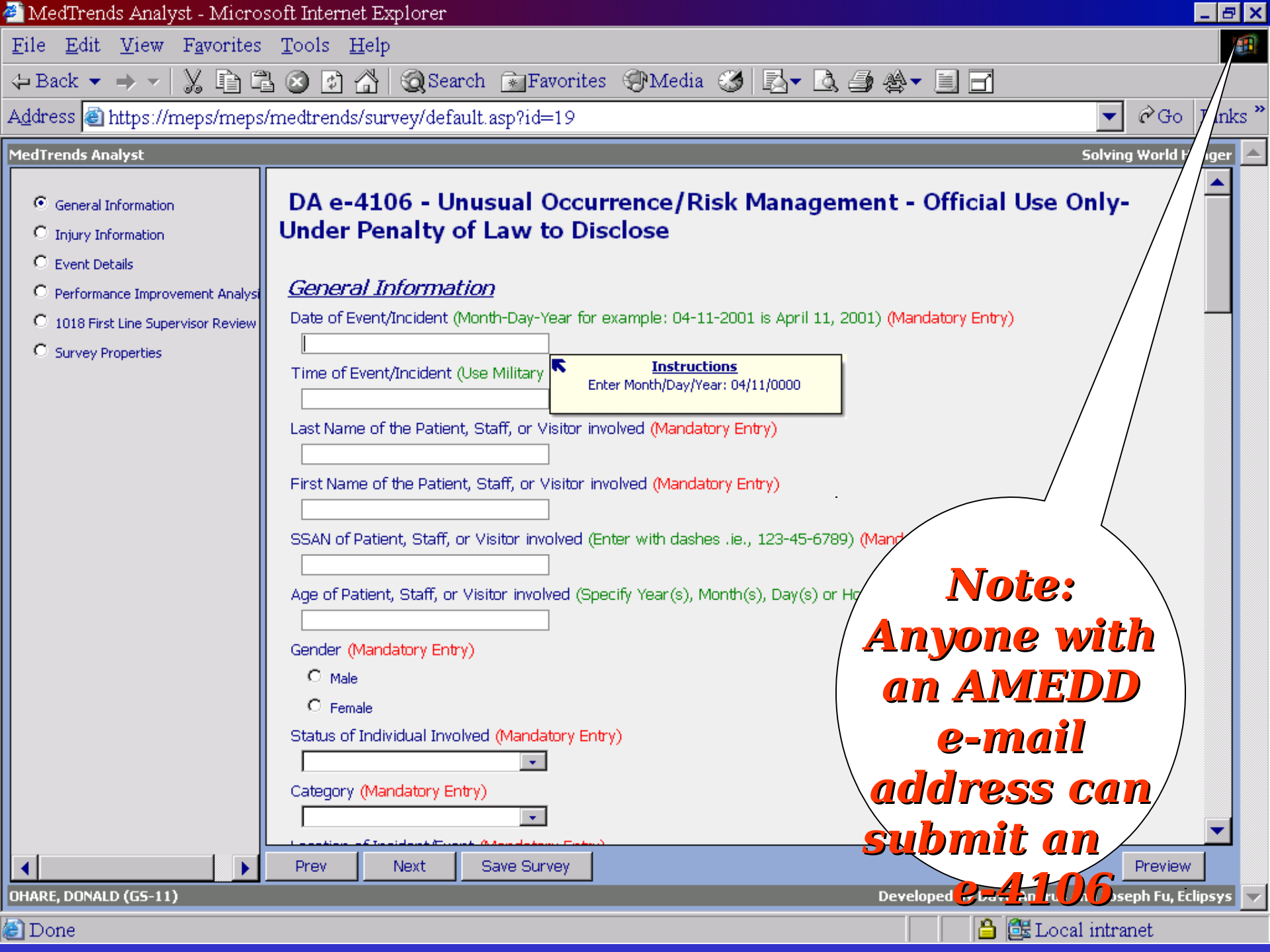
CFC

Outlook Web Access

Note: Paper 4106s are No Longer Accepted

https://meps/meps/medtrends/survey/default.asp?id=19

Internet


MedTrends Analyst - Microsoft Internet Explorer
File Edit View Favorites Tools Help
Back Search Favorites Media
Address https://meps/meps/medtrends/survey/default.asp?id=19
Go Links
MedTrends Analyst
Solving World
General Information
Injury Information
Event Details
Performance Improvement Analysi
1018 First Line Supervisor Review
Survey Properties
DA e-4106 - Unusual Occurrence/Risk Management - Official Use Only-Under Penalty of Law to Disclose
General Information
Date of Event/Incident (Month-Day-Year for example: 04-11-2001 is April 11, 2001) (Mandatory Entry)
Time of Event/Incident (Use Military
Instructions
Enter Month/Day/Year: 04/11/0000
Last Name of the Patient, Staff, or Visitor involved (Mandatory Entry)
First Name of the Patient, Staff, or Visitor involved (Mandatory Entry)
SSAN of Patient, Staff, or Visitor involved (Enter with dashes .ie., 123-45-6789) (Mand
Age of Patient, Staff, or Visitor involved (Specify Year(s), Month(s), Day(s) or Ho
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Status of Individual Involved (Mandatory Entry)
Category (Mandatory Entry)
Prev
Next
Save Survey
Preview
OHARE, DONALD (GS-11)
Developed
oseph Fu, Eclipsys
Note: Anyone with an AMEDD e-mail address can submit an e-4106
Done
Local intranet

JCAHO 2006 National Patient Safety Goals

- 1. Patient Identification
- 2. Communication Among Careg ivers
- 3. Medications Safety
- *7. Risk Reduction Acquired Infections
- **8. Medication Reconciliation s**
- 9. Reduce Patient Falls

Goals 4, 5, & 6 were retired and included in the JCAHO CAMH Standards.

•New Goals are **Bolded**.

"Nurse, get on the internet, go to SURGERY.COM, scroll down and click on the 'Are you totally lost?' icon."

Patient Safety means ***NEVER*** being the LAST TO KNOW!

Patient Safety Officer
x6-7190

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